Home-Based Occupational Therapy: Then and Now

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This paper presents a description of the use of occupational therapy with the homebound patient early in the profession’s history, including a specific case treated in 1925. This description is compared with how such a home program might be practiced today. The differences are in the actual practice of occupational therapy itself, the cost of therapy, and the barriers to referral.

The use of occupational therapy with homebound persons was addressed by Evelyn Lawrence Collins (1921) in the first issue of the journal Archives of Occupational Therapy. In an article entitled “Occupational Therapy for the Homebound,” she stated,

It is no longer necessary to speak of the value of Occupational Therapy and try to prove what it can do and what it has done; we have seen and we know its value, it is no longer questioned. If in the hospitals, however, convalescence may be shortened by the right kind of prescribed work as some of our most eminent physicians have verified, how much more may it do in the home? (p. 33)

Another early account of occupational therapists working with homebound clients was written by Selma Sullivan (1925). In her article she stated that the Home Industries Department of the Association for the Crippled and Disabled of Cleveland had a halftime aide who visited only homebound women in 1917:

At that time, we were able to find but few organizations in the country who were doing similar work and we pioneered for about a year and a half, working out our own ways of designing, buying, compensating the patient, selling his products, interesting the physicians, and listing progress made by the patient physically and financially. (p. 101)

Sullivan went on to state:

Our patients are not many, twenty-four women and twenty-six men, but they are all ages and disabilities, and scattered over the entire city and suburbs. Our Ford covers eighty miles a day. Most of our patients are permanently disabled, so that the work which we take them is of more of occupational than direct therapeutic value. But who knows where to draw the line? Where does the indirect therapeutic value begin? Where do the indirect influences of work end, in the patient, in his family, in his neighborhood? (p. 102)

Referrals came through the social service department, but the occupational therapist tried to educate these social agencies that the aim of occupational therapy was to help the client both physically and mentally, not just financially.

Bertha Strange (1926) who worked with the Committee for the Crippled in the Brooklyn, New York, Bureau of Charities said,

The first and most important step in the work of the Homebound is really mental therapeutics. When the handicapped man is brought to understand that he is no less a man by reason of his physical disability, that he may and can be useful in the community, and the commercial world, we have started on a really therapeutic or constructive work. (p. 121)

Patient History

Sullivan (1925) described a 35-year-old man who was disabled by infantile paralysis. She stated that he was mar-
ried to a "mentally deficient" woman and had three children under the age of 7 years. The patient had been referred by the Associated Charities to the Home Industries Department of the Association for the Crippled and Disabled in Cleveland, Ohio, because he had been "difficult to cooperate with, but perhaps we would go in as he was a cripple, badly handicapped, with no income and a growing family" (Sullivan, 1925, p. 102). Previously, he had earned a meager income by begging but was largely supported by his father. Although badly impaired, he had good general health and was discouraged by inactivity and being unable to support his family. The home occupational therapist taught him to cane chairs and later taught him rush-seating techniques.

The patient recruited friends to distribute cards advertising his trade and wrote to leading furniture houses in his city. With the profits from his work, he bought a secondhand Ford and adapted it to his disabilities. A steel rod attached to the foot brake enabled him to operate it with his hand, and he managed the clutch fairly well, although he wore braces on both legs. Thus the intervention of a home occupational therapist made the difference between a depressed, bored, inactive handicapped man and one that the author described as "a happy man who seems to feel that he is a man among men again, doing his share of the world's work and supporting his family" (Sullivan, 1925, p. 107).

Then and Now

If we compare the occupational therapy intervention of this 1925 case with a similar home program in 1991, we find differences in several areas. The case study illustrates occupational therapy that focused on economic viability as well as on the patient's physical and mental restoration. The salability issue of products made by clients was discussed by Beatrice Lindberg (1926) when she gave the following reasons why patients' products should be sold:

1) To help sustain the patient's interest; 2) to be able to make a variety of projects; 3) as a source for pin money; 4) to make the patient's work self-supporting; 5) to make an institution self-supporting in regard to Occupational Therapy supplies; 6) publicity for the institution and department; 7) to help the patient's self respect; 8) to make patients feel that they are useful because the world has a need and use for their product; 9) to keep the work alive; and 10) the stimulus of sales. (p. 63)

Today, on the other hand, home care focuses on the production of functional outcomes in a safe environment without raising the salability issue.

A second issue is the cost of therapy. Dunton (1926) stated that the unit cost of a basketry project was $.70 per hr and the cost of instruction per person was $.10 per hr. This could be contrasted to the average cost of $15 to $30 per hr paid to a home care occupational therapist in 1991. More importantly, the definition of what constitutes occupational therapy practice has changed. Under Medicare guidelines in 1991, occupational therapy for a chronically ill person in the home would not be reimbursable. Because our case study referred to the patient as a man in good health, no restorative intervention was made. He was not homebound. Today, prevocational and vocational work in the home are not covered by either federal or state programs, although some prevocational testing might be paid for by state or vocational rehabilitation programs.

A further constraint is the requirement for home-based occupational therapy that a primary health care worker (i.e., registered nurse, physical therapist, speech therapist) must be needed before an occupational therapist can intercede. In the 1925 case study, the occupational therapist was working alone with the client.

Summary

Although there are differences in the scope and practice of occupational therapists working with homebound clients in 1925 and 1991, the underlying philosophy remains the same (i.e., the treatment or intervention involves not only the patient, but also his or her environment). Occupational therapists working in an outpatient clinic or home setting should perceive their treatment as curative measures through the use of occupation. Such treatment exercises muscles as well as the mind.▲

References


